



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Fort Duncan Medical Center

**Respondent Name**

Travelers Indemnity Co

**MFDR Tracking Number**

M4-17-0325-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

October 6, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This is originally billed on 10/26/2015 well within the 95 day rule that applies, from the date of service. The first date of submission was via mail on 10/26/2016, which we have attached the send back letter received from the carrier on 12/04/2015, which validates that the carrier received the claim before the deadline. We then corrected the claim with the information requested and the carrier has still denied our date of service."

**Amount in Dispute:** \$338.62

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "As the date of service was 10-05-2015, the Provider herein was required to file their Request with the Division of Workers' Compensation no later than 10-05-2016. As indicated by the Division's date stamp, the Request was filed on 10-06-2016, and consequently was not timely filed."

**Response Submitted by:** Travelers

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2015	99283	\$338.62	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired

- 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medial bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service
- 16 – Claim/service lacks information which is needed for adjudication
- W3 – Additional payment made on appeal/reconsideration
- 947 – Upheld no additional allowance has been recommended

### **Issues**

1. Did the requestor waive the right to medical fee dispute resolution?

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is October 5, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 6, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

		October 31, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**